PRINTED: FORM A

PRINTED: 09/28/2011 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION  A. BUILDING  B. WING			COMI 09/13/	E SURVEY PLETED 2011	
	PROVIDER OR SUPPLIER			1420 S	ADDRESS, CITY, STATE, ZIP CODI F MARY CIRCLE RT, IN46342	E	
(X4) ID PREFIX TAG R0000	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPF DEFICIENCY)	LD BE	(X5) COMPLETION DATE
	Complaint IN000 state residential is allegations is cited. Survey dates: See Facility number: Provider number AIM number: Note and Survey Team: Janelyn Kulik, Round Census bed type Residential: 115 Total: 115 Census bed type Other: 115 Total:	295618- Substantiated, finding related to the ed at R 0349.  Exptember 12 and 13, 2011  002627  CA  N  Significant of the ed at R 0349.  Signi	RO	0000	Plan of Correction is a construed as an admis or agreement with the and conclusions in the Statement of Deficience the proposed administ penalty (with right to con the community. Rasubmitted as confirma our ongoing efforts to with statutory and regrequirements. In this document, we have ous specific actions in reseach allegation or find have not presented all factual or legal argument nor have we identified mitigating factors. We committed to the deliving quality health care ser and will continue to mechanges and improver satisfy that objective.	ssion of findings electes, or trative correct) ather, it is ation of comply ulatory atlined ponse to ling. We contrary ents, if a remain erry of vices ake	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Any defiency statement ending with an asterisk (\*) denotes a deficency which the institution may be excused from correcting providing it is determined that other safegaurds provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION (X3) DATE SU  A. BUILDING  D. WING  O9/13/20			ETED		
			B. WING	G		09/13/2	011
	PROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP CODE  1420 ST MARY CIRCLE  HOBART, IN46342				
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	Ē	(X5) COMPLETION DATE
R0349	on each resident. maintained under temployee of the fa	sible.	R0349 R 349 Clinical Records-				
	Based on 1	record review	R0	349	R 349 Clinical Records- Noncompliance What corre	ctive	09/23/2011
	and interv	iew, the			action(s) will be accomplishe those residents found to have	e	
	facility fai	iled to ensure			been affected by the alleged deficient practice? · Resident # B	nt # B	
	clinical re	cords were			has been discharged from ou community on 9/1/11. How	will	
	maintaine	d with			the facility identify other residuals with the potential to be affect	ed	
	complete a	and accurate			by the same alleged deficien practice and what corrective		
	document	ed resident			action will be taken? · An au of clinical records for resider	nts	
	information	on for 1 or 6			receiving home health servic related to wound care was		
	residents 1	reviewed			completed by the Resident C Director on 9/21/11 to identify		
	related to	incomplete			conflicting / inaccurate documentation regarding wo		
	physician	orders, lack of			type / treatment. There were residents affected by the alle		
	document	ation, and lack			deficient practice. What measures will be put in place		
	of assessm	nent.	<del>.</del>		what systemic changes will the facility make to ensure the alleged deficient practice does not recur? Licensed nursing		
	Resident B			staff were re-educated on 9/21/11, by the resident care director, regarding communit policy on wound care and			

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) M	ULTIPLE CC	ONSTRUCTION	(X3) DATE SURVEY  COMPLETED		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUII		00	09/13/2011	
			B. WIN		ADDRESS, CITY, STATE, ZIP CODE	00/10/2011	
NAME OF F	PROVIDER OR SUPPLIER			1	T MARY CIRCLE		
BRENTW	OOD AT HOBART			HOBAF	RT, IN46342		
(X4) ID PREFIX		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE	COM	(X5)
TAG	*	CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)			Έ	IPLETION DATE
	Findings i				treatments / clinical records documentation. The Resid Care Director educated Hom Health Agency nurses provid wound care in our communit regarding the communities p related to wound care and H	e ing y olicy	
	The closed	d record for			Care Provider Collaboration		
	Resident #	B was			within our community on 9/13/11. How will the corre	I	
	reviewed	on 9/12/11 at			actions be monitored to ensu the deficient practice will not recur, i.e., what quality assur		
	2:10 p.m.	The resident's			programs will be put in place The Resident Care Director	?·	
	diagnoses	included, but			designee will review home h	ealth	
	were not 1	imited to,			discrepancies related to wou care timely. Weekly review	nd	
	diabetes n	nellitus,		be review	be reviewed monthly at the communities Quality Assurar		
	hypertensi	ion, dementia,			meeting, the QA committee vector determine if continued auditi	vill	
	•	y, congestive			necessary based on 6 consecutive months of susta	ined	
		re, coronary			compliance. The communi regional team will randomly a	audit	
	artery dise				during routine visits and duri the annual Comprehensive		
	depression	n, and history			Review Process. By what do will these systemic changes	I	
	of urinary	tract infection.			implemented? · 9/23/11		
	A nursing	note, dated					
	6/7/11 at 8	3:00 p.m.,					
	indicated	the RA					

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:				NSTRUCTION 00	(X3) DATE COMPI		
			A. BUII B. WIN	LDING G		09/13/2	
NAME OF I	PROVIDER OR SUPPLIER	<u> </u>		STREET A	ADDRESS, CITY, STATE, ZIP CODE	-	
BRENTV	VOOD AT HOBART			1	Γ MARY CIRCLE tt, IN46342		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX TAG	` `	CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	ATE	COMPLETION DATE
	(Resident	Aide) found a					
	wound on the resident's						
	left ankle	bone while					
	giving the	resident a bed					
	bath. The	ere was no					
	active ble	eding. The area					
	measured	2 cm					
	(centimete	ers) in					
	diameter.	The physician					
	was called	d and indicated					
	she would	l be in on					
	6/8/11 to s	see the					
	resident.	The physician					
	ordered a	dry dressing to					
	the area.	The dressing					
	was applie	ed. The family					
	was made	aware.					
	A nursing	note, dated					
	6/8/11 at 1	11:46 a.m.,					

AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		A. BUIL B. WING	DING	00 	COMPL 09/13/2	ETED
NAME OF I	PROVIDER OR SUPPLIER		STREET A	DDRESS, CITY, STATE, ZIP CODE		
BRENTV	OOD AT HOBART			MARY CIRCLE T, IN46342		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	ΤE	(X5) COMPLETION DATE
	indicated the physician					
	was in to see the					
	resident. An order was					
	received to clean the left					
	ankle with betadine and					
	apply a dry dressing					
	daily until healed.					
	A nursing note, dated					
	6/9/11 at 7:30 p.m.,					
	indicated "order					
	re-clarification for skin					
	tear to left outer ankle.					
	Clean wound site with ns					
	(normal saline) & (and)					
	apply dry drsg (dressing)					
	until healed. "					
	A physician order, dated					
6/9/11 at 7:30 p.m.,						
	p.m.,					

	STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:				NSTRUCTION 00	(X3) DATE S COMPL	
			A. BUILDI B. WING	ING		09/13/2	
NAME OF F	PROVIDER OR SUPPLIER				DDRESS, CITY, STATE, ZIP CODE  MARY CIRCLE		
BRENTV	VOOD AT HOBART				T, IN46342		
(X4) ID PREFIX		TATEMENT OF DEFICIENCIES  CY MUST BE PERCEDED BY FULL		ID REFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		(X5) COMPLETION
TAG	`	LSC IDENTIFYING INFORMATION)		TAG	CROSS-REFERENCED TO THE APPROPRIADEFICIENCY)	ΓE	DATE
	indicated	skin tear,					
	cleanse w	ound to left					
	outer ankl	e with normal					
	saline and	cover with dry					
	dressing u	intil healed.					
	Review of	fthe					
	Medicatio	n					
	Administr	ration Record					
	for June 2	011, indicated					
	no entry for	or the					
	resident's	left ankle to be					
	cleansed v	with betadine					
	and cover	ed with a dry					
	dressing d	•					
		to be cleansed					
		al saline and					
	covered w	•					
	dressing u	intil healed.					

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLI A. BUILDING	E CON	NSTRUCTION  00	(X3) DATE COMPL	ETED	
	PROVIDER OR SUPPLIER	<u> </u>	1420	O ST	DDRESS, CITY, STATE, ZIP CODE MARY CIRCLE T, IN46342	1	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	(	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	ATE	(X5) COMPLETION DATE
	A nursing	note, dated					
	6/11/11 at	1:00 p.m.,					
	indicated	dressing to left					
	outer ankl	e changed.					
	The treatn	nent was done					
	per physic	cian orders.					
	There was slight yellow						
	drainage r	noted. At 7:05					
	p.m., the	dressing to the					
	left ankle	fell off. The					
	area was o	cleansed with					
	normal sa	line and a dry					
	dressing v	vas applied.					
	There was	s no signs or					
	symptoms	s of infection.					
	There was	s no drainage.					
	A nursing	note, dated					
	6/27/11 at	10:20 a.m.,					
	indicated	home health					

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MU	JLTIPLE CO	INSTRUCTION 00	(X3) DATE SU: COMPLET		
111,2 12,11,	or conduction	DENTITION NO.	A. BUIL B. WINC			09/13/201	
NAME OF F	PROVIDER OR SUPPLIER		-		ADDRESS, CITY, STATE, ZIP CODE		
BRENTV	OOD AT HOBART				T MARY CIRCLE RT, IN46342		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX TAG	*	CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	]	PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE (	COMPLETION DATE
	care was r	notified related					
	to a new c	order for home					
	health to t	reat the					
	wound.						
	A home he	ealth note,					
	dated 6/28	3/11, indicated					
	the type of	f wound was a					
	neuropath	ic (diabetic					
	wound) or	n the left ankle.					
	The stage	of pressure					
	order was	a Stage IV					
	(full thick	ness of skin					
	and subcu	taneous tissue					
	was lost).	The area					
	measured	4.0 by 3.2 by					
	0.4. There	e was a scant					
	amount of	drainage and					
	the wound	l bed was					
	slough (ne	ecrotic or					

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE C  A. BUILDING  B. WING	ONSTRUCTION  00	COM	TE SURVEY  SPLETED  8/2011	
	PROVIDER OR SUPPLIER	<u>  </u>	STREET 1420 \$	ADDRESS, CITY, STATE, ZIP ST MARY CIRCLE RT, IN46342	- CODE	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
	avascular	in the process				
	of separat	ing from viable				
	tissue).					
	A home h	ealth				
	certification	on and plan of				
	treatment,	dated 6/29/11,				
	indicated	a diagnosis of				
	diabetic w	ound to left				
	ankle and	weakness.				
	The woun	d care was				
	cleanse w	ound with				
	normal sa	line, apply				
	bacitracin	, cover with a				
	4 by 4 and	d tape to				
	secure.	•				
	A physicia	an order, dated				
		1:15 p.m.,				
		wound care,				

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			(X2) MULTIPLE CO  A. BUILDING  B. WING	00	COM	TE SURVEY  MPLETED  3/2011
	PROVIDER OR SUPPLIER		1420 S	ADDRESS, CITY, STATE, ZIP CO T MARY CIRCLE RT, IN46342	DDE	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES ICY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION SE CROSS-REFERENCED TO THE A DEFICIENCY)	IOULD BE	(X5) COMPLETION DATE
	cleanse w	ith normal				
	saline, ap	ply polysporin				
	(antibiotic	e) and dry				
	dressing d	laily.				
	A nursing	note, dated				
	6/29/11 at	1:20 p.m.,				
	indicated	the physician				
	was in to	see the resident				
	and a new	order was				
	received t	o cleanse the				
	wound wi	th normal				
	saline, ap	ply polysporin				
	ointment,	and apply a				
	dry dressi	ng.				
	-	_				
	Review of	f the				
	Medication	on				
	Administi	cation Record				
	for July 2	011, indicated				

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUII	LDING	00	COMPLETED 09/13/2011	
			B. WIN		ADDRESS, CITY, STATE, ZIP CODE	09/13/2011	
NAME OF F	PROVIDER OR SUPPLIER				T MARY CIRCLE		
BRENTW	OOD AT HOBART			HOBAR	RT, IN46342		
(X4) ID PREFIX		TATEMENT OF DEFICIENCIES  CY MUST BE PERCEDED BY FULL		ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE	(X5) COMPLETION	
TAG	,	LSC IDENTIFYING INFORMATION)	<u> </u>	TAG	CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	DATE	
	to clean w	ound to left					
	ankle with normal saline,						
	apply poly						
	ointment a	and apply dry					
	dressing p	er home health					
	nurse dail	y. The					
	treatment	was signed out					
	as comple	ted 7/1/11 thru					
	7/14/11 w	ith 7/13/11					
	circle. Th	e back of the					
	Medicatio	n					
	Administr	ration Record					
	indicated	the treatment					
	was not co	ompleted on					
	7/13/11 ar	nd the					
	physician	was notified.					
	A home h	ealth note,					
	dated 7/1/	11, indicated					
	the type o	f wound was					

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPL  A. BUILDING	E CON	NSTRUCTION  00	(X3) DATE COMPL	ETED	
	PROVIDER OR SUPPLIER		142	0 ST	DDRESS, CITY, STATE, ZIP CODE  MARY CIRCLE T, IN46342		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES ICY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	X	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	ATE	(X5) COMPLETION DATE
	pressure o	on the left					
	ankle. Th	ne stage of the					
	pressure v	wound was a					
	Stage IV	with a small					
	amount of	f drainage and					
	the wound	d bed tissue					
	was sloug	h. There were					
	no measu	rements.					
		ealth note,					
	dated 7/5/	11, indicated					
	the type o	f wound was					
	pressure o	on the left					
	ankle. Th	nere was no					
	stage doci	umented. The					
	area meas	sured 2.0 by 2.0					
	by 0.1 cm	(centimeters).					
	There was	s a small					
	amount of drainage and						
	the wound	d bed tissue					

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULT	IPLE CON		(X3) DATE S COMPL		
or condition	IDENTIFICATION NO MIDER.		A. BUILDING			09/13/2011	
NAME OF PROVIDER OR SUPPLIER					<u> </u>		
BRENTWOOD AT HOBART							
SUMMARY STATEMENT OF DEFICIENCIES				PROVIDER'S PLAN OF CORRECTION		(X5) COMPLETION	
,					ΤE	DATE	
was slick	pink.						
A home h	ealth note,						
dated 7/7/	11, indicated						
the type o	f wound was						
pressure o	on the right						
(sic) outer	ankle. The						
stage was not							
document	ed. The area						
measured	2.0 by 2.0 by						
0.1 cm. T	There was a						
small amo	ount of						
drainage a	and the wound						
pink.							
1							
A nursing	note, dated						
	•						
	•						
was III all							
	PROVIDER OR SUPPLIER VOOD AT HOBART  SUMMARY'S (EACH DEFICIENT REGULATORY OR WAS Slick  A home h dated 7/7/the type of pressure of (sic) outer stage was document measured 0.1 cm. The small amount of the date of	DENTIFICATION NUMBER:  PROVIDER OR SUPPLIER  WOOD AT HOBART  SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  Was slick pink.  A home health note, dated 7/7/11, indicated the type of wound was pressure on the right (sic) outer ankle. The stage was not documented. The area measured 2.0 by 2.0 by 0.1 cm. There was a small amount of drainage and the wound bed tissue was slick	PROVIDER OR SUPPLIER  WOOD AT HOBART  SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  Was slick pink.  A home health note, dated 7/7/11, indicated the type of wound was pressure on the right (sic) outer ankle. The stage was not documented. The area measured 2.0 by 2.0 by 0.1 cm. There was a small amount of drainage and the wound bed tissue was slick pink.  A nursing note, dated 7/8/11 at 5:00 p.m., indicated the physician	DENTIFICATION NUMBER:  A BUILDING B WING  STREETA 1420 ST HOBART  SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  Was slick pink.  A home health note, dated 7/7/11, indicated the type of wound was pressure on the right (sic) outer ankle. The stage was not documented. The area measured 2.0 by 2.0 by 0.1 cm. There was a small amount of drainage and the wound bed tissue was slick pink.  A nursing note, dated 7/8/11 at 5:00 p.m., indicated the physician	DESCRIPTION DESCRIPTION NUMBER:  A BUILDING B WING  PROVIDER OR SUPPLIER  JOOD AT HOBART  SUMMARY STATEMENT OF DEFICIENCIES (LACI) DETICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  Was slick pink.  A home health note, dated 7/7/11, indicated the type of wound was pressure on the right (sic) outer ankle. The stage was not documented. The area measured 2.0 by 2.0 by 0.1 cm. There was a small amount of drainage and the wound bed tissue was slick pink.  A nursing note, dated 7/8/11 at 5:00 p.m., indicated the physician	DEPOTIFICATION NUMBER:  A BUILDING NUMBER OF COMPLICATION NUMBER:  STREET ADDRESS. CITY. STATE. ZIP CODE 1420 ST MARY CIRCLE HOBART, IN46342  SUMMARY STATEMENT OF DEFICIENCIES  (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  Was slick pink.  A home health note, dated 7/7/11, indicated the type of wound was pressure on the right (sic) outer ankle. The stage was not documented. The area measured 2.0 by 2.0 by 0.1 cm. There was a small amount of drainage and the wound bed tissue was slick pink.  A nursing note, dated 7/8/11 at 5:00 p.m., indicated the physician	

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			A. BUILDING B. WING		09/13	
NAME OF F	ROVIDER OR SUPPLIER			ET ADDRESS, CITY, STATE, ZIP COD	E	
BRENTW	OOD AT HOBART			ST MARY CIRCLE ART, IN46342		
(X4) ID PREFIX	SUMMARY STATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
TAG	`	CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX TAG	CROSS-REFERENCED TO THE APPL DEFICIENCY)		COMPLETION DATE
	was seen.					
	A home he	ealth note,				
	dated 7/8/	11, indicated				
	the type o	f wound was				
	pressure o	on the left				
	lateral ank	tle. The area				
	measured	2.0 by 2.0 by				
	0.1 cm. T	here was a				
	moderate	amount of				
	drainage a	and the wound				
	bed tissue	was slick				
	pink. Th	ne wound was a				
	Stage III (	a full thickness				
	of skin is	lost, able to see				
	subcutane	ous tissue).				
	A home he	ealth note,				
	dated 7/11	/11, indicated				
	the type o	f wound was				
	7 1					

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) M	(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY COMPLETED	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	- 1	LDING	00	09/13/2	
			B. WIN		ADDRESS, CITY, STATE, ZIP CODE		
	PROVIDER OR SUPPLIER			1	T MARY CIRCLE		
BRENTWOOD AT HOBART				HOBAR	RT, IN46342		
(X4) ID PREFIX		TATEMENT OF DEFICIENCIES  CY MUST BE PERCEDED BY FULL		ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		(X5) COMPLETION
TAG	`	LSC IDENTIFYING INFORMATION)		TAG	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	DATE
	pressure.	There was no					
	stage docu	ımented. The					
	wound me	easured 2.0 by					
	2.0 by 0.1	cm. There					
	was a sma	ll amount of					
	drainage a	and the wound					
	bed tissue was slough.						
	A nursing	note, dated					
	7/13/11 at	12:30 p.m.,					
	indicated	the physician					
	was in to	see the					
	resident.	The physician					
	wanted ho	me health to					
	address th	e foot daily per					
	order and	<b>J</b> 1					
	_	diessing					
	change.						
	<b>A</b>						
	•	note, dated					
	7/14/11 at	8:00 p.m.,					

PRINTED: 09/28/2011 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA  AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CO  A. BUILDING  B. WING	00	СОМ	E SURVEY PLETED /2011
NAME OF PROVIDER OR SUPPLIER BRENTWOOD AT HOBART		1420 S	T MARY CIRCLE	DE	
SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	(EACH CORRECTIVE ACTION SHO	ULD BE	(X5) COMPLETION DATE
indicated	the nurse spoke				
with the re	esident's				
daughter a	and the resident				
was being	admitted to				
the hospit	al for IV				
(intravenc	ous antibiotics)				
for the wo	ound to the				
resident's	left ankle and				
weakness	on the				
resident's	left side of her				
body. Th	e daughter				
indicated	testing was				
being don	e.				
Interview	with the				
Resident Care Director					
on 9/13/1	1 at 10:55 a.m.,				
indicated	she could not				
say how c	often the				
dressing c	change was to				
	provider or supplier vood at hobart  SUMMARY'S  (EACH DEFICIENT REGULATORY OR indicated with the reduced with the reduced was being the hospit (intravence for the work resident's weakness resident's weakness resident's body. The indicated being don Interview Resident on 9/13/1 indicated say how of the supplier of the work resident's weakness resident's weakness resident's body. The indicated being don Interview Resident on 9/13/1 indicated say how of the work resident of the work resident's weakness resident's body. The indicated being don Interview Resident of the work	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  indicated the nurse spoke with the resident's daughter and the resident was being admitted to the hospital for IV (intravenous antibiotics) for the wound to the resident's left ankle and weakness on the resident's left side of her body. The daughter indicated testing was being done.  Interview with the	PROVIDER OR SUPPLIER  WOOD AT HOBART  SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  indicated the nurse spoke with the resident's daughter and the resident was being admitted to the hospital for IV (intravenous antibiotics) for the wound to the resident's left ankle and weakness on the resident's left side of her body. The daughter indicated testing was being done.  Interview with the Resident Care Director on 9/13/11 at 10:55 a.m., indicated she could not say how often the	OF CORRECTION DENTIFICATION NUMBER:  A BUILDING B WING  STREET ADDRESS, CITY, STATE, ZIP COT 1420 ST MARY CIRCLE HOBART, IN46342  SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  indicated the nurse spoke with the resident's daughter and the resident was being admitted to the hospital for IV (intravenous antibiotics) for the wound to the resident's left ankle and weakness on the resident's left side of her body. The daughter indicated testing was being done.  Interview with the Resident Care Director on 9/13/11 at 10:55 a.m., indicated she could not say how often the	PROVIDER OR SUPPLIER  ### WOOD AT HOBART    SUMMARY STATEMENT OF DEFICIENCIES   1420 ST MARY CIRCLE   HOBART, IN46342

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CO  A. BUILDING  B. WING	00	i i	E SURVEY PLETED /2011	
NAME OF PROVIDER OR SUPPLIER BRENTWOOD AT HOBART			1420 S	ADDRESS, CITY, STATE, ZIP C T MARY CIRCLE RT, IN46342	CODE	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES  (EACH DEFICIENCY MUST BE PERCEDED BY FULL  REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF COI (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
	be comple	eted that was				
	ordered or	n 6/9/11. The				
	staff shou	ld have				
	indicated	that				
	information	on. She also				
	indicated	she did not				
	know why the treatment					
	was not included on the					
	Medicatio	on				
	Administr	ration Record				
	and did no	ot how often it				
	had been	completed. It				
	should ha	ve been				
	document	ed on the				
	Medication					
	Administr	ration Record.				
	She also i	ndicated she				
	had inforr	ned staff they				
	were not t	o sign that				
	treatments	s had been				

AND PLAN OF CORRECTION IDENTIFICATION NUMBER:				NSTRUCTION 00	COMPL		
			A. BUILDING B. WING			09/13/2011	
NAME OF I	PROVIDER OR SUPPLIER	I		DDRESS, CITY, STATE, ZIP CODE	1		
BRENTV	OOD AT HOBART			「MARY CIRCLE T, IN46342			
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIES		ID PROVIDER'S PLAN OF CORRECTION PREFTY (EACH CORRECTIVE ACTION SHOULD BE			(X5)	
PREFIX TAG	(EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		PREFIX TAG	CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		COMPLETION DATE	
	completed that were						
	being done by the home						
	health nurse. She further						
	indicated she could not						
	say who was completing						
	the dressing change to						
	the wound the staff had						
	signed out as completed.						
	She further indicated if						
	the staff had been doing						
	the dressing changes as						
	was documented on the						
	Medication						
	Administration Records						
	they should have been						
	assessing the resident's						
	wound.						
	Interview with the						
	Resident Care Director						

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			ULTIPLE CO LDING	INSTRUCTION 00	(X3) DATE COMPI		
				IG		09/13/2	011
NAME OF PROVIDER OR SUPPLIER					ADDRESS, CITY, STATE, ZIP CODE  T MARY CIRCLE		
BRENTWOOD AT HOBART				HOBAR	RT, IN46342		
(X4) ID PREFIX		STATEMENT OF DEFICIENCIES NCY MUST BE PERCEDED BY FULL		ID PROVIDER'S PLAN OF CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APP		3	(X5) COMPLETION
TAG		R LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
		1 at 1:30 p.m.,					
	indicated	the resident's					
	physician	had been					
	aware of	the resident's					
	wound an	nd had seen the					
	wound or	n several					
	occasions	s. She indicated					
	she had only seen the						
	wound w	hen it was first					
	observed	and it was a					
	skin tear.	She was not					
	aware the	home health					
	nurse had	indicated the					
	wound wa	as a					
	neuropath	nic ulcer and a					
	pressure ulcer.						
	•						
	This state	residential					
	finding re	elates to					
		nt IN00095618.					
	- Compining						

	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	A. BUILDING	00 	COMP: 09/13/2	LETED
NAME OF PROVIDER OR SUPPLIER  BRENTWOOD AT HOBART			T MARY CIRCLE		
SUMMARY S (EACH DEFICIEN	CY MUST BE PERCEDED BY FULL	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOUL	D BE	(X5) COMPLETION DATE
	OF CORRECTION PROVIDER OR SUPPLIER OOD AT HOBART SUMMARY S (EACH DEFICIEN	OF CORRECTION IDENTIFICATION NUMBER: PROVIDER OR SUPPLIER	OF CORRECTION DENTIFICATION NUMBER:  A. BUILDING B. WING  PROVIDER OR SUPPLIER  JOOD AT HOBART  SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL  ON THE PROVIDENCY AND THE PROVIDENCE OF THE PROVIDENCE	OF CORRECTION IDENTIFICATION NUMBER:  A. BUILDING B. WING  PROVIDER OR SUPPLIER  STREET ADDRESS, CITY, STATE, ZIP CODE 1420 ST MARY CIRCLE HOBART, IN46342  SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL)  PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPR	OF CORRECTION IDENTIFICATION NUMBER:  A. BUILDING B. WING  STREET ADDRESS, CITY, STATE, ZIP CODE 1420 ST MARY CIRCLE HOBART, IN46342  SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL  OO DESCRIPTION OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE